The Implications of Missouri's First-in-the-Nation Assistant Physician Legislation

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Each year, thousands of medical school graduates fail to secure postgraduate training through the National Resident Matching Program.[1] To date, job opportunities for these individuals who would like direct involvement in patient care have been limited. They cannot work as medical practitioners because their lack of postgraduate training renders them ineligible for licensure in any state.[2] US graduates may pursue health care–related employment with the intent of reapplying for residency training, or pursue a nonclinical career path altogether. Additionally, foreign medical graduates may practice in certain countries outside of the United States indefinitely while attempting to obtain a residency position.

Recently, Missouri created another option for those lacking residency training. Legislation enacted in 2014 established the position of "assistant physician," defined as an individual who may be licensed to function as a primary care provider following a brief apprenticeship.[3] This novel approach may draw the interest of stakeholders in other states. However, the consequences of the assistant physician legislation for patient safety and health care quality should be addressed before this approach is considered for broader adoption.

Key Provisions of Missouri's Assistant Physician Legislation

The main intent of the law is to increase the availability of primary care providers in Missouri. Like many parts of the country, the number of primary care practitioners in the state is not adequate, despite the presence of several medical schools in addition to programs dedicated to the training of advanced practice nurses and physician assistants.[4] This shortage in Missouri may be exacerbated by its state legislature's reluctance to expand Medicaid coverage under the Affordable Care Act.[5] A possible intent of the legislation is that the additional providers made available by the assistant physician legislation may rectify this problem. In addition, assistant physicians may be less expensive to employ than either fully trained physicians or midlevel providers, so this approach may have appeal to legislators, policymakers, and health care administrators.

Briefly, the assistant physician law will apply to graduates of US and the international medical schools listed in the *World Directory of Medical Schools* and will limit practice to providing primary care services to underserved rural and urban locales. As defined, these services include prescribing controlled substances, "performing routine therapeutic procedures," "assisting in surgery," and "other tasks not prohibited by law"[3] (BOX). Assistant physicians will be required to maintain a collaborative practice agreement with a supervising physician. For the first month of practice, the supervising physician must be continuously present; thereafter, the assistant physician can practice within a 50-mile radius of his or her supervisor. A supervising physician may enter into such collaborative practice agreements with as many as 3 assistant physicians. Finally, the statute directs that educational programs be put in place to "facilitate the advancement of the assistant physician's knowledge and capabilities, and which may lead to credit toward a future residency program."[3] As the details of operationalizing the law are being finalized, it is anticipated that individuals can apply for licensure as an assistant physician as early as 2016.

Problems With Implementation

Medical school graduates lacking additional "graduate" training are not typically viewed as possessing the knowledge and skills necessary to practice independently. Thus, the principal barrier to implementing the assistant physician law centers on how these individuals would be trained and supervised. Traditional residency programs in primary care specialties (ie, internal medicine, family medicine, or pediatrics) are 3 years in duration, are highly structured to provide a well-rounded and rigorous clinical and educational experience, and are based in environments that have clinical education as a core

DOI: http://dx.doi.org/10.4300/JGME-D-15-00341.1

mission.[6] The goals and objectives of these programs are established by the Accreditation Council for Graduate Medical Education.[7] Trainees achieve educational milestones by providing care under the supervision of physician educators, attending educational conferences, and engaging in independent reading and self-study. Standard approaches to assessment (such as in-service examinations and rotation evaluations completed by faculty) are used not only to examine the trainees' knowledge base, clinical skills, and professionalism, but also to identify trainees in need of additional training and remediation. With progression through residency, trainees are afforded greater autonomy, based in part on these assessments.[8] Board certification is conferred on those who successfully complete residency training and meet performance benchmarks on a certifying examination.[6] Accumulating evidence suggests that the quality of care provided by board-certified physicians is superior to that of physicians who have not attained this benchmark, including individuals who have not completed residency training.[9–11]

In contrast, there is no infrastructure in place for training or supervising assistant physicians, or for monitoring the quality of care those individuals deliver. The 1-month period of direct supervision provided by the law appears arbitrary, and no standard assessment tools are used to determine whether assistant physicians are competent to practice autonomously. Aside from maintaining active licensure, supervising physicians are not required to possess any specific credential, such as board certification in a primary care specialty.[3] These individuals may have completed as little as 1 year of postgraduate training themselves (the minimum required for independent licensure in Missouri), and most will lack expertise as an educator.[2] Finally, while 1 intent of the law is ostensibly to serve as a pathway for medical school graduates to enter residency training, it is unclear how serving as an assistant physician would be of educational value or otherwise further the career prospects of these individuals.

Additional concerns exist. Medical school graduates who are not successful at securing a residency position may not possess the same academic credentials, clinical skills, and interpersonal qualities as those who secure a position. Similarly, the quality of education provided by some international medical schools may be inferior to education available at universities in the United States. Both groups may be grossly unprepared for the rapid transition into independent practice and would particularly benefit from the highly structured environment residency training provides. The foregoing arguments notwithstanding, it might be argued that assistant physicians possess training equal to, if not exceeding that of, advanced nurse practitioners who are allowed to practice independently in many locations. Conceivably, assistant physician–styled laws might be a strategy on the part of organized medicine to counter the growing independence of this nursing specialty.[12,13]

BOX Key Provisions of Missouri's Assistant Physician Legislation

- Eligibility limited to US and foreign medical school graduates who have not begun residency training.
- Assistant physicians are restricted to providing only primary care services in underserved rural and urban areas.
- Scope of practice includes, but is not limited to, taking histories and performing physical examinations. Assistant physicians may perform routine therapeutic procedures and assist in surgeries. These individuals are prohibited from prescribing medication or performing abortions.
- Assistant physicians must maintain active collaborative practice agreements with a supervising physician. The supervising physician must be continuously present for at least a 1-month period before allowing the assistant physician to engage in unsupervised practice.
- After the supervisory period, the assistant physician must practice within a 50-mile radius of the supervising physician. The supervising physician must review $\geq$ 10% of patient records for which the assistant physician has provided care ($\geq$ 20% of patient records if controlled substances have been prescribed).
- A supervising physician may not enter into collaborative practice agreements with more than 3 assistant physicians.

Advanced practice nurses are certified in 1 of several areas (eg, acute care, gerontology, etc) after completion of master's or doctoral level training in accredited programs, which involve a minimum of 500 hours of supervised clinical care.[14] Their scope of practice is defined in all 50 states. The training of physician assistants is similarly rigorous.[15] Accumulating evidence suggests that midlevel providers deliver high-quality, cost-effective care.[16,17] Thus, while an assistant physician license might be granted to inadequately trained individuals to practice in settings in which they have little expertise, midlevel providers are specifically educated and credentialed in a narrowly defined focus.

What Lessons Can Be Drawn From This Legislation?

Missouri's assistant physician law is a public response designed to bridge critical gaps in the health care workforce. This is to be achieved by disregarding

established approaches to medical education developed over decades at substantial expense. At the same time, the passage of this law emphasizes the need for greater social accountability on the part of training institutions. Furthermore, the Missouri legislation also illustrates the need for dialogue between the academic community, state legislatures, and professional societies regarding issues that directly affect physician training. Finally, while the assistant physician model may have appeal as a strategy to expand primary care services, its effects on the health care workforce and patient outcomes should be understood before broad implementation.

References

1. The Match, National Resident Matching Program: results and data. Results of the 2015 NRMP applicant survey. http://www.nrmp.org/wp-content/uploads/2015/09/Applicant-Survey-Report-2015.pdf. Accessed October 12, 2015.
2. State Medical Licensure Requirements and Statistics. Chicago, IL: American Medical Association e-Book; 2014:29–30.
3. Senate Bill No. 716: 97th General Assembly, 2014. http://www.house.mo.gov/billtracking/bills141/billpdf/commit/SB0716C.pdf. Accessed October 12, 2015.
4. Hing E, Hsiao CJ. State variability in supply of office-based primary care providers: United States, 2012. *NCHS Data Brief*. 2014;151:1–8.
5. Hicks LL, Boren S, Leung R, Bouras A, Kimberling A, Myers K, et al. The economic impacts of Medicaid expansion on Missouri, November 2012. http://www.mffh.org/mm/files/MUMedicaidExpansionReport.pdf. Accessed October 12, 2015.
6. *ABMS Member Board Requirements for General Certification*. Chicago, IL: American Board of Medical Specialties; 2012.
7. Accreditation Council for Graduate Medical Education. Program and institutional accreditation. https://www.acgme.org/acgmeweb/tabid/83/ProgramandInstitutionalAccreditation.aspx. Accessed October 27, 2015.
8. Schumacher DJ, Bria C, Frohna JG. The quest toward unsupervised practice: promoting autonomy, not independence. *JAMA*. 2013;310(24):2613–2614.
9. Norcini JJ, Kimball HR, Lipner RS. Certification and specialization: do they matter in the outcome of acute myocardial infarction? *Acad Med*. 2000;75(12):1193–1198.
10. Brennan TA, Horwitz RI, Duffy FD, Cassel CK, Goode LD, Lipner RS. The role of physician specialty board certification status in the quality movement. *JAMA*. 2004;292(9):1038–1043.
11. Sharp LK, Bashook PG, Lipsky MS, Horowitz SD, Miller SH. Specialty board certification and clinical outcomes: the missing link. *Acad Med*. 2002;77(6):534–542.
12. Tavernise T. Doctoring, without the doctor. *The New York Times*. May 25, 2015. http://www.nytimes.com/2015/05/26/health/rural-nebraska-offers-stark-view-of-nursing-autonomy-debate.html?_r=0. Accessed October 12, 2015.
13. Institute of Medicine. The future of nursing: leading change; advancing health. Washington, DC: National Academies Press; 2013. http://iom.nationalacademies.org/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx. Accessed October 12, 2015.
14. American Nurses Credentialing Center. http://www.nursecredentialing.org. Accessed October 12, 2015.
15. American Academy of Physician Assistants. Become a PA. https://www.aapa.org/become-a-pa. Accessed October 27, 2015.
16. Mundinger MO, Kane RL, Lenz ER, Totten AM, Tsai WY, Cleary PD, et al. Primary care outcomes in patients treated by nurse practitioners or physicians: a randomized trial. *JAMA*. 2000;283(1):59–68.
17. Moote M, Krsek C, Kleinpell R, Todd B. Physician assistant and nurse practitioner utilization in academic medical centers. *Am J Med Qual*. 2011;26(6):452–460.

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